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Regional PPOs in Medicare: What Are The Prospects?

How Do They Contain Rising Costs?

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Introduction

One of several new types of Medicare health plans that became available for the first time in 2006, regional Medicare preferred provider organizations (PPOs) promised to import the successful commercial PPO model to the Medicare market. Policymakers anticipated that regional PPOs could provide access to comprehensive coverage (including for prescription drugs) at affordable costs to all Medicare beneficiaries. This Findings Brief summarizes recent research and experience related to regional Medicare PPOs and assesses the prospects for this type of health plan in the near future.

This research was part of a larger project funded in July 2004 by the Robert Wood Johnson Foundation's Changes in Health Care Financing and Organization (HCFO) program. The goal of the project is to provide early and timely information on entry, enrollment, and risk selection of Medicare prescription drug plans and regional PPOs. The research team, led by Steven D. Pizer, Ph.D., assistant professor at the Boston University School of Public Health, includes Austin B. Frakt, Ph.D., health systems research scientist at Boston University, and Roger Feldman, Ph.D., Blue Cross Professor of Health Insurance at the University of Minnesota.

Over the course of the project, we have explored adverse selection in stand-alone prescription drug plans (PDPs), the entrance of PPOs into regional markets where health maintenance organizations (HMOs) already exist, and the entry of PDPs and PPOs in markets where HMOs did not have a presence. To predict the viability of these newly created Medicare products, we built statistical models of market entry and enrollment for similar private products available to Medicare beneficiaries prior to the Medicare Modernization Act of 2003 (MMA). These models were used to simulate market entry and costs for the new plans in a variety of competitive situations.

Our model predicted:

- Stand-alone PDPs would be likely to enroll beneficiaries with disproportionately high expenditures for prescription drugs, but enrollment would be large and stable nevertheless.[a]

- Regional PPOs would be unlikely to attract large and stable enrollments without very costly ongoing subsidies from the Medicare program. We estimated that PPO enrollment would cost approximately $1,598 in additional subsidy per enrollee, or over $6 billion to enroll fewer than 4 million beneficiaries for one year.

Our predictions held up in the subsequent year. However, it is important to note that regional PPOs appear to be filling an important gap for rural beneficiaries.

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[a] For detailed results focused on PDPs, see "A Sustainable Future?: The Role of Premium Subsidies in Medicare Prescription Drug Plans," HCFO Findings Brief Vol. IX, No. 4, January 2007.

New Types of Plans

The Medicare Modernization Act of 2003 (MMA) created a new statutory minimum for outpatient prescription drug coverage under Medicare, starting in January 2006. In order to receive this coverage, Medicare beneficiaries were required to enroll in a private health plan, either a Medicare HMO or one of several new types of health plans created by the law. Prominent among these were the regional preferred provider organization (PPO) and the regional prescription drug plan (PDP).

Regional PPOs were modeled on the dominant plan type in the commercial health insurance market. Commercial PPOs combine comprehensive coverage with affordable premiums by negotiating discounts from providers who participate in the plan's network. This combination has attracted over 151 million enrollees in the commercial market.[1] In light of this success, early enthusiasm for PPOs in Medicare was high. Tom Scully, CMS Administrator in 2003 testified that "the President's plan is based on combining the best of Medicare—a community-rated social insurance health plan—with the option chosen by . . . 130 million Americans, the flexible PPO benefit model."[2]

Unlike the previously established Medicare HMOs, regional PPOs were required by MMA to do business in regions defined by CMS, including both urban and rural areas. Existing HMOs were permitted to continue defining their own service areas, typically avoiding sparsely populated rural counties. Perhaps to help offset this competitive asymmetry, MMA provided a $10 billion "stabilization fund" to encourage PPOs to enter the market. Taking this incentive approach further, CMS adopted a ratemaking rule that would pay PPOs substantially more than HMOs per enrollee if they disproportionately attracted enrollment from rural counties.[b]

The other major new plan type created by MMA was the regional PDP. These plans were designed to offer stand-alone prescription drug coverage, a product that did not previously exist in the commercial market. Because of the lack of experience with this plan type and concerns about the predictability of drug claims, health policy experts expressed doubts about the viability of these plans.[3]

Predictions

In August of 2005, before the new plans began to enroll beneficiaries, we predicted the likely market entry and enrollment patterns for regional PPOs.[c] Using county-level CMS data from 1993-2001 on premiums, benefits, and enrollment patterns combined with data from the Area Resource File we constructed a statistical model of market entry and costs for regional PPOs under several competitive scenarios. The model generated predictions for the new plan types based on recent experience from the period prior to their introduction. Given how different the new plan types are from what had gone before, we

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[b] Details of this rule are described in Pizer S., Feldman, R., and Frakt, A.B. "Defective Design: Regional Competition in Medicare." *Health Affairs*: Web Exclusive W5-400, August 23, 2005, pp 399-411.

[c] Details of the analysis and results are described in Pizer S., Feldman, R., and Frakt, A.B. "Defective Design: Regional Competition in Medicare." *Health Affairs*: Web Exclusive W5-400, August 23, 2005, pp 399-411.

knew the precision of the model's predictions would be limited, but we believed important lessons might emerge despite this limitation.

The model indicated that regional PPOs were unlikely to enroll large numbers of beneficiaries and that competition from geographically specialized HMOs would make it impossible for regional PPOs to prosper without substantial, ongoing subsidies beyond those available to other plan types. We estimated the cost to the government of switching rural beneficiaries from traditional Medicare to regional PPO coverage under current rules at $1,598 per enrollee, or over $6 billion to enroll fewer than 4 million beneficiaries for one year.

The root cause for this gloomy outlook was uneven competition among plan types. Because PPOs are regional, they must contract with providers in sparsely populated areas where discounts are difficult or impossible to obtain; their HMO competitors simply avoid these areas. Furthermore, regional PPOs must offer comprehensive coverage (both drug and non-drug), unlike their PDP competitors. Both PPOs and PDPs must offer coverage in sparsely populated areas, but PDPs contract for services with drug manufacturers and pharmacy chains, negotiating discounts nationally. Only regional PPOs are required to contract locally with physicians and hospitals in areas where they have no leverage.

Early Experience

It is now possible to compare these early predictions with actual experience in the first year of the new plan types' operations. We make three comparisons: market entry, enrollment, and premiums.

Considering market entry first, regional PPOs have entered the Medicare market unevenly and in small numbers. Five of the 26 regions defined by CMS had no regional PPO entrants at all. Four had only one regional PPO and five had only two. The full distribution of entrants and their geographical locations are shown in Exhibit 1.[4] The entry pattern of regional PPOs in Exhibit 1 is sparse compared with market entry by regional PDPs; all PDP regions had at least 27 entrants in 2006.

EXHIBIT 1 Distribution Of Regional Preferred Provider Organizations (PPOs) And Medicare Advantage (MA) Regions, 2006

Number of regional PPOs	Number of MA regions	MA regions (states)
0	5	1 (ME, NH), 2 (CT, MA, RI, VT), 20 (CO, NM), 23 (ID, OR, UT, WA), 26 (AK)
1	4	3 (NY), 4 (NJ), 22 (TX), 25 (IA, MN, MT, ND, NE, SD, WY)
2	5	6 (PA, WV), 10 (GA), 11 (FL), 17 (IL), 24 (KS)
3	4	5 (DE, DC, MD), 9 (SC), 19 (AR), 21 (LA)
4	7	7 (VA), 12 (AL, TN), 13 (MI), 14 (OH), 15 (IN, KY), 16 (WI), 18 (MO)
8	1	8 (NC)

Source: Frakt, A.B., and Pizer, S.D. "A First Look at The New Medicare Prescription Drug Plans." Health Affairs 25: Web Exclusive, May 23, 2006, pp w252-w261.

Turning to enrollment, figures recently released by CMS indicate that regional PPOs attracted less than one percent of Medicare Part D enrollment in 2006.[5] This compares with 22 percent for local HMOs and 72 percent for PDPs. Total enrollment in Part D was 22.5 million beneficiaries.[d]

Lastly, although the cost of coverage provided by regional PPOs is not directly observable to researchers, some evidence can be gleaned from the premiums charged by these plans. On average, regional PPOs charged $67 per month for comprehensive coverage in 2006, 34% more than the average premium charged by local HMOs.[6]

Overall, a review of the experience from 2006 suggests that our predictions for regional PPOs were fairly accurate. This new plan type did not play a large role in Medicare. Dramatic changes would seem to be required before prospects for regional PPOs could improve.

Looking Ahead

As we predicted, regional PPOs did not enter the market or enroll beneficiaries in large numbers in 2006. What are the implications for Medicare beneficiaries in the future? We think the key question is whether Medicare is committed to regional plans or not. Regional plans were created to make comprehensive coverage affordable in rural areas that historically have been avoided by HMOs. If local HMOs did not exist, regional PPOs could combine profitable urban areas with unprofitable rural areas as envisioned by the authors of MMA. As long as local HMOs retain superior territorial flexibility, however, regional PPOs cannot compete. Consequently, what MMA created in the form of regional PPOs, it simultaneously undermined by exempting existing local plans from regional requirements.

Of course, now that the success of PDPs has been established, one of the reasons for supporting regional PPOs no longer applies. PDPs are available in rural areas and provide drug coverage at premiums that are widely viewed as affordable, despite being more expensive than drug coverage from local HMOs.[7]

On the other hand, PDPs do not address the need for affordable, comprehensive non-drug coverage in rural areas. If the law remains as currently structured, any regional PPOs that survive until 2008 probably will convert to local plans and withdraw from unprofitable rural counties, ending the experiment with comprehensive regional plans.[e] Rural Medicare beneficiaries who want comprehensive coverage will have to combine traditional Medicare, a Medigap plan to cover non-drug cost-sharing, and a PDP for drug coverage. This combination cost approximately $180 per month in 2006, compared with

[d] These figures include the following plan types: Employer/union, MA-PD (HMO, PPO and PFFS), PDP, PACE, Cost, and Demo. Medicaid recipients are excluded.

[e] In an effort to support the start-up of regional plans, MMA imposed a temporary moratorium on new local plans for 2006 and 2007.

$50 for coverage from local HMOs available to urban beneficiaries.[f] Given these premium differences, rural beneficiaries have a lot to lose if Medicare abandons regional PPOs.

Regardless of the policy direction ultimately chosen by Congress and the Administration, the research summarized in this Findings Brief demonstrates the potential value of statistical models that predict how Medicare health plans and their potential enrollees will respond to contemplated policy changes. We hope these models will continue to be useful as the new benefits and plan types created by MMA are refined in the years ahead.

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[1] American Association of Preferred Provider Organizations, "About AAPPO," 2007, aappo.org (11 January 2007).
[2] T.A. Scully, Centers for Medicare and Medicaid Services, "On Strengthening and Improving the Medicare Program," Testimony before the Senate Finance Committee, 6 June 2003.
[3] Pauly, M., and Zeng, Y. "Adverse Selection and the Challenges to Stand Alone Prescription Drug Insurance." NBER Working Paper No. W9919, August 2003.
[4] Frakt, A.B., and Pizer, S.D. "A First Look at The New Medicare Prescription Drug Plans." *Health Affairs* 25: Web Exclusive, May 23, 2006, pp w252-w261.
[5] Cubanski, J. and Neuman, P. "Status Report on Medicare Part D Enrollment in 2006: Analysis of Plan-Specific Market Share and Coverage." *Health Affairs* Web Exclusive November 21, 2006, ppW1-12.
[6] Kaiser Family Foundation, "Medicare Health and Prescription Drug Plan Tracker," www.kff.org/medicare/healthplantracker (11 January 2007).
[7] Kaiser Family Foundation and Harvard School of Public Health, "The Public's Health Care Agenda for the New Congress and Presidential Campaign." December 2006, http://www.kff.org/kaiserpolls/upload/7598.pdf (11 January 2007).

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[f] Estimated by combining average premiums for Medigap plan F in 2005 ($140 per month) with average premiums for a PDP in 2006 ($37) (sources: confidential communication with a major national Medigap insurer and Kaiser Family Foundation).